Hospice Care

Hospice Care

Providers must be enrolled as a Health First Colorado (Colorado's Medicaid Program) provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

Hospice services are available to Health First Colorado members with a terminal illness (life expectancy of nine (9) months or less). The palliative treatment includes services and interventions that are not curative but provide the greatest degree of relief and comfort for the symptoms of the terminal illness.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing hospice care.

Billing Information

Refer to the General Provider Information manual for general billing information.

Hospice Benefits

The member may receive Health First Colorado Hospice Benefit (MHB) services in a:

- Private residence
- Residential care facility (Alternative Care)
- Licensed hospice facility
- Intermediate Care Facility for the Mentally Retarded (ICFMR)
- Skilled Nursing Facility (SNF)
- Nursing Facility (NF)

Health First Colorado Hospice Benefit members residing in a nursing facility must meet hospice level of care and financial Health First Colorado eligibility criteria.

Hospice SNF/NF room and board reimbursement is made to the hospice provider for each home care level day (routine or continuous care).

- The member must choose MHB services.
- The member's attending physician must certify that the member is terminal.
- Both the member and the attending physician must agree to the plan of care developed by the hospice provider.
- A participating MHB provider must provide all MHB services.
- Hospice services are co-payment exempt.
- Physician services are not a covered MHB; they are billed by the physician as a regular physician service.
- The SNF/NF provides the hospice with the room and board per diem amount for hospice members residing in an SNF/NF. The hospice bills room and board on behalf of the member to the Health First Colorado which reimburses 95% of the per diem amount, and the hospice passes the room and board payment through to the SNF/NF.

The patient liability amount may apply when a hospice member resides in a NF. This is payment made by the member for NF care, after the personal needs allowance and other approved expenses are deducted from member income. The personal needs allowance and other approved deductions are

determined by County Income Maintenance Technicians. The patient liability amount must be applied to the member's care.

When reporting the patient liability amount for the entire month, regardless of the number of days in that month, apply the total patient liability.

Example:

Bill the full $100.00 (Per Diem Rate) amount
The processing system automatically deducts 5% – $100 X .95= $95.00
$95.00 X 31 = $2,945.00
$2,945.00 - $500.00 = $2,445.00 (NF R & B)
$2,445.00 + $3,500.00 (routine home care amount) = $5,945.00 Total Reimbursement.

Use the per diem calculation to calculate the correct amount when reporting the patient liability amounts for less than one full month of NF care. The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.

To calculate NF partial patient liability:

1. Calculate the Health First Colorado amount by multiplying the number of days for payment times the per diem amount.

2. If the Health First Colorado amount exceeds the patient liability amount, the partial month's patient liability amount remains the same as the regular patient liability amount.

3. If the patient liability is more than the Health First Colorado amount, the partial month's patient liability is the same as the Health First Colorado amount. The excess of the patient liability over the partial month's patient liability belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident. It is the SNF's/NF's responsibility to collect patient liability. The hospice does not have to collect patient liability. The hospice may choose to collect this amount and pay the SNF/NF.

Revenue Coding

Bill Hospice services with the following revenue codes:

Service	Revenue Code	Description
Hospice Routine Home Care	**650**	Care Days 1-60 One Unit = 1 day
	651	Care Days 61+ One Unit = 1 day
Continuous Home Care	**652**	One Unit=1 hour (must be at least 8 hours in a 24 hour period with more than half provided by a nurse)
Service Intensity Add-on	**652**	One Unit=1 hour (up to 4 hours and member must be seen by a nurse or social worker within the last 7 days of life)
Hospice Inpatient Respite	**655**	One Unit = 1 day

Hospice General Inpatient Care	**656**	One Unit = 1 day
Hospice Physician Service (Visit)	**657**	One Unit = 1 visit Non-covered MHB service (Non-covered charges must be shown in both FL 53 and 54)
Hospice NF Room and Board Per/Diem	**659**	One unit = 1 day

Post Eligibility Treatment of Income (PETI)
Nursing Facility Supplemental Benefits

Post Eligibility Treatment of Income (PETI) is defined as the reduction of resident payment to a nursing facility for costs of care provided to an individual for services not covered by the Medical Assistance Program, by the amount that remains after certain approved deductions are applied, and paid to the providers to reduce the individual's total payment.

- The individual is liable to pay the remaining amount to the institution.

- Members who reside in a nursing facility, are receiving hospice services and who are making a patient liability payment must have a letter from their primary care physician stating why these additional services are medically necessary and requested by the resident.

- These requests will be considered individually and the Department will determine whether or not to approve the request.

- The Long Term Care (LTC) facility or the family determines the need for Non-Medical Assistance Program covered services.

- The facility or family arranges for the member to see the provider.

All PETI expenses must be prior authorized by the Department. **Prior Authorization Requests (PARs) should be sent to:**

PETI Program
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

PETI Revenue Codes			
479	Hearing	**969**	Dental
962	Vision	**999**	Health insurance/other

Hospice agencies are responsible for adding PETI codes to their claims for Medical Assistance Program members living in nursing facilities and who also make a patient liability payment. Once the charges are approved, the hospice agency may submit claims for the PETI payment on the claim with the member's room and board minus patient liability amount. The claims processing system will automatically complete the calculations.

Bill PETI charges in units. One unit equals one dollar.

Example with Claim: If a member has been approved for the purchase of eyeglasses at a cost of $175, the PETI amount equals 175 units at $1.00 each. Do not bill partial units or cents.

Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		3a PAT CNTL # SM000123 b MED REC # 6 FED. TAX NO. 6 STATEMENT COVERS PERIOD FROM 10/06/2016 THROUGH 10/31/2016	4 TYPE OF BILL 812

8 PATIENT NAME		9 PATIENT ADDRESS	123 Main Street			
b Client, Ima D.		b Anytown		CO	88888	

10 BIRTHDATE	11 SEX	12 DATE ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
02/13/1980	F	10/06/2016 1		30			

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37
27 10/06/2016								

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
		a		
		b		
		c		
		d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		10/06/16	8	624.00		
652	Hospice Continuous Home Care		10/18/16	24	480.00		
652	Hospice Continuous Home Care		10/19/16	16	320.00		
652	Hospice Continuous Home Care		10/20/16	8	160.00		
655	Hospice Inpatient Respite		10/21/16	3	249.00		
656	Hospice General Inpatient Care		10/24/16	1	350.00		
651	Hospice Routine Home Care		10/25/16	9	702.00		
659	Nursing Facility R & B Per Diem		10/06/16	20	1100.00		
962	Vision and Eye Care		10/06/16	175	175.00		
	PAGE 1 OF 1	CREATION DATE	TOTALS		4160.00	165.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
D - Medicaid	1234567890				3995.00		

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Client, Ima D.		A123456		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	C184	C781	J43.9								68
0											

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a OTHER PROCEDURE CODE DATE	b OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 1234567890 QUAL
				LAST Provider FIRST Ima
c OTHER PROCEDURE CODE DATE	d OTHER PROCEDURE CODE DATE	e OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL LAST FIRST
80 REMARKS	81CC a b c d		78 OTHER NPI QUAL LAST FIRST
			79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450
© 2005 NUBC   OMB APPROVAL PENDING   NUBC   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 Paper Claim Reference Table

Hospice services must be provided and billed only by a certified Hospice provider**.**

The information in the following table provides instructions for completing form locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual.* Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for Health First Colorado as those indicated in the *NUBCUB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator **may not** be used for submitting paper claims to Health First Colorado. The appropriate code values listed in this manual must be used when billing Health First Colorado.

The UB-04 Institutional Certification document (located in the Provider Services Forms section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices in the Provider Services Billing Manuals section.

Do not submit continuation claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted through the Provider Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to Health First Colorado for hospice care services.

Form Locator and Label	Completion Format	Instructions
1. **Billing Provider Name, Address, Telephone Number**	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state in the address to the standard post office abbreviations. Enter the telephone number.

2. Pay-to Name, Address, City, State	Text	Required on if different from FL 1.
		
		Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services:
		
		    Street/Post Office box
		    City
		    State
		    Zip Code
		
		Abbreviate the state in the address to the standard post office abbreviations.

3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.

4. **Type of Bill**	3 digits	Required
		Use the following code range for Hospice:
		811-815 for non-hospital based Hospice services
		821-825 for hospital based Hospice services
		The three-digit code requires one digit from each of the sequences (Type of facility, Bill classification, & Frequency).
		Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences:
		Digit 1 - Type of Facility:
		8 - Special Facility (Hospice)
		Digit 2 - Bill Classification (Special facilities Only):
		1 - Hospice (Non-Hospital Based)
		2 - Hospice (Hospital Based)
		Digit 3 - Frequency:
		0 - Non-Payment/Zero Claim
		1 - Admit Through Discharge Claim
		2 - Interim - First Claim
		3 - Interim - Continuous Claim
		4 - Interim - Last Claim
		5 - Late Charge(s) Only Claim
5. **Federal Tax Number**	None	Submitted information is not entered into the claim processing system.

6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill.
6. Statement Covers Period – From/Through **(continued)**	From: 6 digits MMDDYY Through: 6 digits MMDDYY	"From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/08 thru 01/30/08 and 02/01/08 thru 02/15/08, not 01/15/08 thru 02/15/08). Match dates to the prior authorization if applicable. If patient is admitted and discharged the same date, that date must appear in both fields. Detail dates of service must be within the "Statement Covers Period" dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the client's city exactly as it appears on the eligibility verification or as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state exactly as it appears on the eligibility verification or as determined at the time of admission.

9d. **Patient Address – Zip**	Digits	Required Enter the client's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 07012015 for July 1, 2015. Use the birthdate that appears on the eligibility verification.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Required Enter the date care originally started from any funding source (e.g., Medicare, Health First Colorado, Third Party Resource, etc.).
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Not Required
15. Source of Admission	1 digit	Required

16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Required Enter client status as ongoing patient (code 30) or as of discharge date. Agencies are limited to the following codes: 01 Discharged to Home 03 Discharged/Transferred to SNF 04 Discharged/Transferred to ICF 05 Discharged/Transferred to Another Type of Institution 06 Discharged/Transferred to organized Home Health Care Program (HCBS) 07 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still patient (ongoing) 40* Expired at home 41* Expired in hospital, SNF, ICF, or free-standing hospice 42* Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility *Hospice use only*
18-28. Condition Codes	2 Digits	Required Z4 necessary for paper claims. Enter the code that matches the program and the prior authorization. Condition Codes (as applicable): 04 - HMO Medicare enrollee 07 - Treatment of non-terminal condition/hospice patient 17 - Patient over 100 years old 39 - Private room medically necessary
29. Accident State		Submitted information is not entered into the claim processing system.

31-34. Occurrence Code/Date	2 digits and 6 digits	Required Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. Occurrence Codes 27 - Date Hospice Plan Established 42 - Date of Discharge (Hospice Benefit Termination)
35-36. Occurrence Span Code From/ Through	2 digits	Not Required
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Fields and codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

39-41. Value Code and Amount (continued)	2 characters and 9 digits	01	Most common semiprivate rate (Accommodation Rate)
		06	Medicare blood deductible
		14	No fault including auto/other
		15	Worker's Compensation
		31	Patient Liability Amount (see below)*
		32	Multiple Patient Ambulance Transport
		37	Pints of Blood Furnished
		38	Blood Deductible Pints
		40	New Coverage Not Implemented by HMO
		45	Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour).
		49	Hematocrit Reading - EPO Related
		58	Arterial Blood Gas (PO2/PA2)
		68	EPO-Drug
		80	Covered Days
		81	Non-Covered Days
			Enter the deductible amount applied by indicated payer:
		A1	Deductible Payer A
		B1	Deductible Payer B
		C1	Deductible Payer C
			Enter the amount applied to client's co-insurance by indicated payer:
		A2	Coinsurance Payer A
		B2	Coinsurance Payer B
		C2	Coinsurance Payer C
			Enter the amount paid by indicated payer:
		A3	Estimated Responsibility Payer A
		B3	Estimated Responsibility Payer B
		C3	Estimated Responsibility Payer C
			Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above

39-41. Value Code and Amount (continued)	* **Patient Liability Amount** is payment made by the client for care, after the personal needs allowance and other approved expenses are deducted. The personal needs allowance and other approved deductions are determined by County Income Maintenance Technicians. This patient liability must be applied to the client's care.	
	When reporting patient liability for the entire month, regardless of the number of days in that month, apply the total patient liability.	
	When reporting patient liability amounts for less than one full month of care, use the per diem calculation to calculate the correct amount.	
	The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.	
	The claim will be denied if the billed amount exceeds this allowed amount.	
	To calculate patient liability:	
	1. Calculate the Health First Colorado amount by multiplying the number of days for payment times the per diem amount.	
	2. If the Health First Colorado amount exceeds the patient liability, the partial month's patient liability remains the same as the regular patient liability amount.	
	3. If the patient liability is more than the Health First Colorado amount, the partial month's patient liability is the same as the Health First Colorado amount. The excess of the patient liability over the partial month's patient liability belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident.	
	When client has Medicare "Part B only" coverage, and the provider is billing for the Health First Colorado Accommodation Per Diem and the payer source code is H, enter the "Part B only" ancillary services payment in this field on the Medicare line.	
42. **Revenue Code**	4 digits	Required If billing for nursing facility per diem charges (Revenue Code 0659 or 0651), the nursing facility provider number must be entered in FL 78 (Other Phys. ID) See Revenue Code table
43. **Revenue Code Description**	Text	Required Enter the revenue code description or abbreviated description.
44. **HCPCS/Rates/ HIPPS Rate Codes**		

45. Service Date	6 digits	Required
		For span bills only Enter the date of service using MMDDYY format for each detail line completed.
		Each date of service must fall within the date span entered in FL 6 (Statement Covers Period).
46. Service Units	3 digits	Required
		Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers.
		Example: Do not enter 1.0 to signify one unit.
		For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required
		Enter the total charge for each line item.
		Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts.
		A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Conditional
		Enter incurred charges that are not payable by the Health First Colorado.
		Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.

50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate Health First Colorado.
50. Payer Name (continued)	1 letter and text	Source Payment Codes B Workmen's Compensation C Medicare D Health First Colorado E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	10 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.

55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or patient liability.
55. Estimated Amount Due (continued)	Up to 9 digits	**Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability.
56. National Provider Identifier (NPI)	10 digits	Required Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the client's name on the Health First Colorado line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes shown on the card.

61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Conditional
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).

66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
		
		Enter applicable ICD indicator to identify which version of ICD codes is being reported.
		
		    0 ICD-10-CM (DOS 10/1/15 and after)
		
		    9 ICD-9-CM (DOS 9/30/15 and before)

67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact ICD-10-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Optional Enter the ICD-10-CM diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not Required
71. PPS Code		Not Required
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the ICD-10-CM diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E."
74. Principal Procedure Code/ Date	7 characters and 6 digits	Not Required

74A. Other Procedure Code/Date	7 characters and 6 digits	Conditional
		Complete when there are additional significant procedure codes.
		Enter the ICD-10-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending NPI – Required	NPI - 10 digits	Health First Colorado ID Required
		NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number.
		(If the attending physician is not enrolled in Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)
Attending- Last/ First Name		Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in Health First Colorado.
	Text	QUAL – Enter "1D" for Medicaid
		Enter the attending physician's last and first name.
		This form locator must be completed for all services.
77. Operating- NPI		Submitted information is not entered into the claim processing system.

78-79. Other ID **NPI – Conditional**	NPI - 10 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. Health First Colorado does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Hospice Claim without Nursing Facility Room and Board with Physician Charges Example

Hospice Agency						3a PAT CNTL #	SM000123			TYPE OF BILL
100 Saginaw Street						b MED REC #				812
Anytown, CO 80201					5 FED TAX NO		STATEMENT COVERS PERIOD			
303-333-3333							FROM 10/06/2016	THROUGH 10/31/2016		

8 PATIENT NAME		9 PATIENT ADDRESS	123 Main Street				
Client, Ima D.		Anytown				CO	88888

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR / 14 TYPE / 15 SRC	16 DHR	17 STAT	CONDITION CODES			
02/13/1980	F	10/06/2016	1		30	Z4			

31 OCCURRENCE CODE/DATE	32 OCCURRENCE CODE/DATE	33 OCCURRENCE CODE/DATE	34 OCCURRENCE CODE/DATE	35 OCCURRENCE CODE/DATE	36 OCCURRENCE SPAN FROM/THROUGH	36 OCCURRENCE SPAN FROM/THROUGH	37
27 10/06/2016					10/06/2016 10/31/2016		

39 VALUE CODES CODE/AMOUNT	40 VALUE CODES CODE/AMOUNT	41 VALUE CODES CODE/AMOUNT
a		
b		
c		
d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		10/06/16	8	624.00		
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652	Hospice Continuous Home Care		10/19/16	16	320.00		
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655	Hospice Inpatient Respite		10/21/16	3	249.00		
656	Hospice General Inpatient Care		10/24/16	1	350.00		
651	Hospice Routine Home Care		10/25/16	9	702.00		
657	Hospice Physician Service		10/06/16	3	165.00	165.00	

PAGE 1 OF 1   CREATION DATE   TOTALS → 3050.00   165.00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
D - Medicaid	1234567890				2885.00	57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Client, Ima D.		A123456		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	C184	C781	J43.9						68

69 ADMIT DX	70 PATIENT REASON DX a / b / c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE/DATE	a OTHER PROCEDURE CODE/DATE	b OTHER PROCEDURE CODE/DATE	75	76 ATTENDING NPI 1234567890	QUAL
				LAST Provider FIRST Ima	
a OTHER PROCEDURE CODE/DATE	c OTHER PROCEDURE CODE/DATE	e OTHER PROCEDURE CODE/DATE		77 OPERATING NPI	QUAL
				LAST FIRST	

80 REMARKS	81 CC a/b/c/d	78 OTHER NPI	QUAL
		LAST FIRST	
		79 OTHER NPI	QUAL
		LAST FIRST	

UB-04 CMS-1450   OMB APPROVAL PENDING   © 2005 NUBC   NUBC National Uniform Billing Committee LIC9213257   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Hospice Claim with Nursing Facility Room and Board Example

	Hospice Agency									34 RAT CNTL # SM000123				TYPE OF BILL
	100 Saginaw Street									b. MED REC #				812
	Anytown, CO 80201									5 FED. TAX NO	STATEMENT COVERS PERIOD			
	303-333-3333										FROM 10/06/2016	THROUGH 10/31/2016		

8 PATIENT NAME		9 PATIENT ADDRESS		123 Main Street									
b. Client, Ima D.		b. Anytown						CO	88888				

10 BIRTHDATE	11 SEX	12. DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
02/13/1980	F	10/06/2016		1			30	Z4						

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
27 10/06/2016				10/06/2016 10/31/2016		

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		10/06/16	8	624.00		
652	Hospice Continuous Home Care		10/18/16	24	480.00		
652	Hospice Continuous Home Care		10/19/16	16	320.00		
652	Hospice Continuous Home Care		10/20/16	8	160.00		
655	Hospice Inpatient Respite		10/21/16	3	249.00		
656	Hospice General Inpatient Care		10/24/16	1	350.00		
651	Hospice Routine Home Care		10/25/16	9	702.00		
659	Nursing Facility R&B Per Diem		10/06/16	26	1100.00		

	PAGE 1 OF 1		CREATION DATE	TOTALS ➜	3985.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
D - Medicaid	1234567890				3985.00		OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Client, Ima D.		A123456		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	C184	C781	J43.9	C	D	E	F	G	H	67
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DIX	70 PATIENT REASON DIX	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE DATE	a OTHER PROCEDURE CODE DATE	b OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 1234567890	QUAL
				LAST Provider FIRST Ima	
c OTHER PROCEDURE CODE DATE	d OTHER PROCEDURE CODE DATE	e OTHER PROCEDURE CODE DATE		77 OPERATING NPI	QUAL
				LAST FIRST	
80 REMARKS		81CC a		78 OTHER NPI 1234567890	QUAL
		b		LAST Nursing Facility FIRST Ima	
		c		79 OTHER NPI	QUAL
		d		LAST FIRST	

UB-04 CMS-1450
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Hospice Claim with Patient Pay Example

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
651	Hospice Routine Home Care		10/06/16	8	624.00	
652	Hospice Continuous Home Care		10/18/16	24	480.00	
652	Hospice Continuous Home Care		10/19/16	16	320.00	
652	Hospice Continuous Home Care		10/20/16	8	160.00	
655	Hospice Inpatient Respite		10/21/16	3	249.00	
656	Hospice General Inpatient Care		10/24/16	1	350.00	
651	Hospice Routine Home Care		10/25/16	9	702.00	
659	Nursing Facility R&B Per Diem		10/06/16	20	1100.00	

Note: Bill services with Health First Colorado rates or usual and customary charges, whichever

All detail line days must be equal to or be less than day in FL 6. Do not include revenue code 659 units.

Nursing Facility room and board "day"" values of revenue codes.

Top of form details:

- Hospice Agency, 100 Saginaw Street, Anytown, CO 80201, 303-333-3333
- 3a PAT CNTL # SM000123
- 4 TYPE OF BILL 812
- 6 STATEMENT COVERS PERIOD FROM 10/06/2016 THROUGH 10/31/2016
- 8 PATIENT NAME: Client, Ima D.
- 9 PATIENT ADDRESS: 123 Main Street, Anytown, CO 88888
- 10 BIRTHDATE 02/13/1980
- 11 SEX F
- 12 ADMISSION DATE 10/06/2016
- 15 SRC 1
- 17 STAT 30
- 18 Z4
- 31 OCCURRENCE CODE 27 DATE 10/06/2016
- 34 OCCURRENCE SPAN FROM 10/06/2016 THROUGH 10/31/2016

		651=8 days
Line 1 = 1st date of 8 days		
Line 2 = 1 day (date specific)		652=1 day
Line 3 = 1 day (date specific)		652=1 day
Line 4 = 1 day (date specific)		652=1 day
Line 5 = 3 days (1st date of 3 days)		655=0 days
Line 6 = 1 day (1st date of 1 day)		655=0 days
Line 7=9 days (1st date of 9 days)		651=9 days
FL 6=24 Days		659=20 days

PAGE 1 OF 1

CREATION DATE

TOTALS ➡ 3985.00

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
D - Medicaid	1234567890		3985.00	

- 58 INSURED'S NAME: Client, Ima D.
- 60 INSURED'S UNIQUE ID: A123456
- 66 DX: C184   C781   J43.9
- 76 ATTENDING NPI 1234567890 — LAST Provider FIRST Ima
- 78 OTHER NPI 1234567890 — LAST Physician FIRST Ima

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____   Date: _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Hospice Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx.*	*2, 16*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx.*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx.*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*
6/15/2018	*Updated timely filing information and removed references to LBOD; removed general billing information already available in the General Provider Information manual*	*2-3, 8, 26*	*DXC*
6/27/2018	*Revision to timely filing*	*26*	*HCPF*

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.